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March 7, 2016

Public Health Committee Hearing
Room 1D LOB

TESTIMONY S.B. No 353 "AN ACT CONCERNING OPIOID ABUSE

INCLUDING SUGGESTIONS FOR TWO ADDITIONAL SECTIONS

The Epidemic

Connecticut's opioid epidemic has been with us for at least 8 years, and has never been worse than it is today. More of our millennial-aged (18-30ish) residents are dying of accidental opioid overdoses than from any other cause. Continuous family anguish starts when they discover their child is using, and is lifelong if the sufferer expires. And the loss of 50+ years of a sufferer's potential to his/her family, community and society is incalculable.

Opioid dependency at its core is a medical condition. It begins with novelty-seeking or pain relieving voluntary decisions to use. Continued use causes control to erode. Finally, there is complete loss of control. Measurable abnormalities within the brain drive compulsive use; with treatment, those abnormalities can be restored over time…the brain 're-wires.' When the condition is untreated or undertreated, it is all too frequently fatal. That is why we are here.

Support for- and Suggestions to improve S.B. No. 353

S.B. No 353 will, if taken alone, take too long to benefit patients who are literally dying in 2016. But the bill provides the opportunity to add action steps that can be applied today. We owe that to the anguished families of suffering Opioid Use Disturbed (OUD) people.

The section (c)(1) states "A strategy for offering medication-assisted treatment at every location…" this bill needs action steps to help now.

1. **Suggested addition: "Emergency departments and hospitals that treat opioid overdoses, must provide addiction evaluations, and where appropriate, refer such patients to inpatient or outpatient treatment."**

2. **Suggested addition: "Private inpatient treatment centers must inform their opioid use disturbed patients about medication assisted treatment and provide transition of care linkages in order to be certified to treat patients with this condition."**

In this testimony I will go into detail about private inpatient treatment centers' patterns because many of my office patients were their patients.

Private Inpatient Drug Treatment Centers

In 2016, many private inpatient drug treatment centers care for more opioid dependent young people than ever before. Their admissions and readmissions make up a significant percentage of income. Some persist in treating their opioid patients like alcoholics, even though opioid withdrawal syndrome, the benefits of medication assisted treatment and transition of care are much different.

WHAT DOES AA THINK? (Hint: Abstinence is not an absolute for recovery)

The Alcoholics Anonymous (AA) principle of abstinence recognizes that some conditions' outcomes improve with medications.

One of AA's approved brochures, **"The AA MEMBER—MEDICATIONS & OTHER DRUGS,"** states *"However, some alcoholics require medications--- It becomes clear that just as it is wrong to enable or support any alcohol to become re-addicted to any drug, it's equally wrong to deprive any alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems."*

Who Am I?

Since 2004, my private internal medicine office in New Fairfield, Connecticut has prescribed buprenorphine to about 500 patients. We follow the NIDA 13 Principles of effective opioid treatment; I use an in-office-developed initial consult form that has helped me understand more about patients than just their drug use. My practice received SAMHSA's Science and Service Award for Office Based Opioid Treatment. I am also certified in addiction medicine by the American Society of Addiction Medicine and an Attending in the Department of Medicine, Danbury Hospital.

Most of My Patients Are Local/Regional

Most of my "bup" patients were born in Connecticut's northern Fairfield and southern Litchfield Counties; they graduated from local high schools, and continue to reside here. They have, or had good jobs before we met, and were, or are in college. Many have moved back with their parents for financial reasons. They have commercial insurance made possible by the Affordable Care Act.

By the time the patients arrive at my office for their initial consult, some parents have already paid part or all of the fees required for one or two or even more (!) drug rehabs…$30-60,000. At the point of our meeting everybody is mistrustful, financially spent and unaware of the benefits of Medication Assisted Treatment (MAT), having learned little or nothing about it in their rehab experience. They know they have a chronic disease, but are surprised to learn that opioid use disorder (OUD) is a chronic disease requiring long, focused, high quality counseling and monitoring.

Opioid Withdrawal Syndrome is Different

Opioid withdrawal occurs in two phases: acute and post-acute. Drug treatment centers medicate the several-day acute phase, but not the post-acute-syndrome (PAWS); the onset of that syndrome appears during the remainder of rehab, and continues at home for weeks or months. I've had patients who lie on couches for weeks after discharge, and decide to use again. The centers do not sufficiently educate patients about PAWS, and what their options are because abstinence is policy. Symptoms of PAWS include insomnia, irritability, craving, dysthymia, impulsivity and a rapidly falling tolerance for opioids. It is a period of increased vulnerability to overdose, fatal or otherwise. If they relapse during the critical period of PAWS, their Primary option might be to seek readmission! Science indicates the use of medication assisted treatment use is dramatically superior to abstinence, but the rehabs in my area insist keeping to their old ways.

As mentioned above, many of my buprenorphine patients get when they are in drug centers is information on abstinence (remember 'just say no'?). Staff, their authorities and parents support abstinence, despite science. This is at the same time when patients are about to enter a sustained period of weeks or months of sustained discomfort. For OUD (opioid use disturbed) patients whose control of use has declined, abstinence may work in some, but for those whose control is lost, continuous abstinence not likely.

The growing opioid epidemic is taking some of our best human treasure. Our response must be smart, comprehensive and evidence-based. We are far from that goal now. Your leadership is needed to stop using AA principles as an excuse to withhold best practices. Even coercion is justified, just as Medicare is doing in our nation's hospitals.

What Are The Ethics of 'Failing to Warn'?

The failure to warn is a fundamental medical principle; it has legal, ethical, financial and health consequences. OUD patients must not be kept in a state of ignorance while in licensed drug centers when that failure to educate can, in the worst case, cause premature mortality. As described above, the period of time when an OUD patient experiences PAWS is among the highest relapse risk-periods, and it occurs immediately after discharge from treatment facilities. Patients and their families, who pay $30-60,000 for one or two inpatient experiences, have every right to expect that information, and the drug center has the responsibility to provide that information.

OUD patients and their families have every right to expect that licensed rehabs provide 'best practice' information. The brain disease model of Addiction makes clear why patients on substitution therapy (MAT) do better than those who are abstinent post discharge from drug treatment facilities.

Conclusions and Recommendations

Evidence based treatment is based on studies and experience. Using those practices in medicine offer the best hope for 'doing it right the first time.'

I urge the Public Health Committee to add my two suggestions to S.B.353

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